Medicaid Information Bulletin

July 2004

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BULLETINS BY TYPE OF SERVICE

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04 - 58 Reporting Third Party Payments (TPL)

Before submitting a claim to Medicaid, a provider must submit and secure payment from all other liable parties such as Medicare Part A and B. (For more information refer to the Medicaid Provider Manual, General Information Section, 11-4). Providers are required to report TPL payment (payer prior payment), patient estimated amount due and contractual writeoffs from prior payers. Specific billing instructions for providers submitting paper claims are available on the Medicaid website at www.health.utah.gov/medicaid .

No Explanation of Benefits (EOB) from prior payer(s) is required unless payment is denied, or when a Medicare/Medicaid Coordination of Benefits (crossover) claim is submitted past the timely filing requirement of 6 months. Claims denied from Medicare as non-covered services should be submitted to Medicaid fee-for-service (not crossovers). Do not include co-payments received from the patient in the TPL reporting. ☐

04 - 59 Dental

Beginning July 2, 2004, a temporary adult dental benefit will begin. This will cover only non-pregnant adults aged 21 and older who are covered by the Traditional Medicaid Program.

The dental benefit is limited and is funded with one-time money by the Legislature. The benefit will end when the allocated funds run out, which is projected to be about February or March of 2005. **The Medicaid recipients are responsible to pay for the dental exams and any cleaning or preventive services they choose to receive, as well as other dental services not provided in this limited scope of service, such as dentures, partial dentures or crowns.** You may choose to offer a reduced exam fee at the Medicaid rate or charge your usual and customary exam fee. Do not bill Medicaid for the examination fees or preventive services. Medicaid will pay for X-rays, fillings, simple tooth extractions--but not extractions for unerupted or impacted teeth, and root canals for permanent teeth up to and including the first molars–second and third molars are eluded from root canal therapy. The program is limited to the following covered dental codes:

D0210, D0220, D0230, D0270, D0274, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D7140, D7210. D3310, D3320, D3330

This does not change the dental benefit for those age 20 and younger nor for adults while they are pregnant. Those benefits remain unchanged. Those who are on Non-Traditional Medicaid will continue to have dental emergency coverage only. Remember, this is a temporary, limited, one-time benefit and will last only until the funding runs which is estimated to be sometime in March or April of 2005. You will be notified when the program ends in FY2005. Thank you for treating Medicaid dental recipients.

Clarification on root canals for pregnant adults

Root canal therapy is a covered benefit for children, age 20 years and younger, excluding third molars. Root canal therapy is covered for pregnant adults excluding second and third molars.

Therapeutic pulpotomy treatment is covered for primary teeth only. Root canal therapy for primary teeth is excluded. ☐

04 - 60 Attention: Federally Qualified Health Centers and Rural Health Clinics

Effective July 1, 2004, the following CPT codes have been opened and may be billed by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for health and behavior assessment/intervention services.

The *CPT Professional 2004* book describes these codes as follows:

> Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.

The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments. The focus of the intervention is to improve the patient's well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems.

Codes 96150-96155 describe the services offered to patients who present with established illnesses to symptoms, who are not diagnosed with mental illness, and may benefit from evaluations that focus on the biopsychosocial factors related to the patient's physical health status. These services do not represent preventive medicine counseling and risk factor reduction interventions.

Opened Codes for Health and Behavior Assessment/Intervention

This range of codes for assessment of biopsychosocial factors is intended for **use by non physician providers**. The following codes should be billed when such services are furnished by clinical psychologists, clinical social workers, or nurse practitioners when performed in an FQHC or RHC setting.

96150 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment

96151 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment

96152 Health and behavior intervention, each 15 minutes, face-to-face; individual

96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)

96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)

96155 Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)

For health and behavior assessment and/or intervention performed by a physician, see **Evaluation and Management** services codes.

Limitations

FQHCs and RHCs will not be reimbursed for both **Health and Behavior Assessment/Intervention** codes and any other of the **Evaluation and Management** services codes when provided on the same day.

The RHCs and FQHCs using the prospective payment system (PPS) may bill one encounter rate per day for all services with the code T1015. The code T1015 could include the service for codes 96150-96155. FQHCs not under PPS may bill for each service provided, but must follow the guidelines for appropriate billing of codes within the CPT manual and per correct coding initiative guidelines described above.

Clients Enrolled in a Managed Care Plan Covering Physical Health Services

Clients enrolled in a managed care plan that covers physical health services (Health Plan) must receive all health care services covered by the Health Plan through the Health Plan in which the client is enrolled. FQHCs and RHCs need to follow the Health Plan's requirements for prior authorization, etc. If you have questions about being reimbursed by the Health Plan, please contact the Health Plan prior to providing the service. ☐

04 - 61 Home Health Codes Revised

The Home Health codes were recently reviewed and some service definitions revised. The revisions can be found in the new Section 6 of the Home Health Manual which is attached for your convenience in updating your manual. ☐

04 - 62 Home Health Payment (HHA) Adjustment

In a letter dated March 17, 2004, all HHA providers were notified of a need to adjust the payment rate on certain payment codes. This adjustment was required to restore a level of payment to these codes that was historically consistent. The movement to the HIPAA requirements was the cause for this underpayment and these changes are intended to alleviate this. This change was made retroactive for all services provided on or after October 1, 2003. A summary of these changes is as follows:

HHA CODE PAYMENT CHANGES – EFFECTIVE 10/01/03

OLD MCD CODE	NEW MCD CODE	HIPAA (NEW CODE) PAYMENT STRUCTURE	REVISED PAYMENT STRUCTURE (Effective Oct. 1, 2003)	REVISED PAYMENT RATE (Effective Oct. 1, 2003)	EFFECTIVE DATE
Y2081	T1019	$3.50 PER 15 MINUTE INCREMENT	Per Hour	$14.00	"RETRO" TO OCTOBER 1, 2003
Y8020	T1002	$9.88 PER 15 MINUTE INCREMENT	Per Visit	$79.06	"RETRO" TO OCTOBER 1, 2003
Y0102	T1003	$9.00 PER 15 MINUTE INCREMENT	Per Visit	$72.07	"RETRO" TO OCTOBER 1, 2003
Y0115	S9122	$18.83 PER HOUR INCREMENT	Per Visit	$37.66	"RETRO" TO OCTOBER 1, 2003
Y0117	S9123	$39.53 PER 15 HOUR INCREMENT	Per Visit	$79.06	"RETRO" TO OCTOBER 1, 2003
Y0105	S9124	$36.00 PER 15 MINUTE INCREMENT	Per Visit	$72.07	"RETRO" TO OCTOBER 1, 2003

Additionally, the following "aging waiver" codes were revised on March 26, 2004. This change, however, was completed on a prospective basis, i.e., for services provided on or after March 27, 2004.

"AGED WAIVER CODE CHANGES" – EFFECTIVE 3/27/04

OLD MCD CODE	NEW MCD CODE	HIPAA (NEW CODE) PAYMENT STRUCTURE	REVISED PAYMENT STRUCTURE (Effective 3/27/04)	REVISED PAYMENT RATE (Effective 3/27/04)	EFFECTIVE DATE
Y0466	S5130U3	$5.97 PER 15 MINUTE INCREMENT	HOUR	$23.88	Prospective for services delivered on or after March 27, 2004
Y0465, 70526	S5150U3	$5.63 PER 15 MINUTE INCREMENT	HOUR	$22.52	Prospective for services delivered on or after March 27, 2004
Y0527	T1005U3	$8.00 PER 15 MINUTE INCREMENT	HOUR	$32.00	Prospective for services delivered on or after March 27, 2004

The provider will be required to "rebill" all previously submitted claims that are affected by this change. ☐

04 - 63 Change from Health Plan Monthly Choice to Annual Choice

Beginning July 1, 2004 eligible Medicaid clients will be required to stay with the same Health Plan for up to twelve months. This applies only to clients living in Davis, Salt Lake, Utah and Weber Counties, who are required to enroll in a Health Plan.

Clients currently enrolled with a Health Plan are being given the option of changing their Health Plan before June 20, 2004 for the fiscal year of July1, 2004 through June 30, 2005. There will be an open enrollment period in June of each year allowing Health Plan enrollees to switch plans effective July 1st of each year.

There are a limited number of reasons that the Medicaid agency will approve a client's request to switch Health Plans during the twelve month period. Providers must continue to verify each patient's eligibility every time a client presents for care, prior to services being rendered, as Medicaid eligibility and Health Plan enrollment can still change from month to month.

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04 - 64 Child Health Evaluation and Care Manual and Immunization Schedule (Appendix B) Updated

We have updated the Utah Medicaid Provider Manual for Child Health Evaluation and Care Program (CHEC) Services as follows:

- We have added clarifications to SECTION 2.
  1. 2-1 Screening and Prevention Services
     We have added oral screening to the comprehensive health screening. The American Academy of Pediatrics (AAP) recommends that each child receive an oral screening by the age of six months by a pediatrician or qualified pediatric health care provider. The oral health screening is a portion of the comprehensive screening. Do not bill the oral health screening separately.

  2. Appendix C - Child Health Evaluation and Care Recommended Schedule
     - We have added Oral Screening as a service at the appropriate ages.
     - We have made an addition to Footnotes #7 screening.
       "Most children should have the initial dental referral made at 12 months. However, if after performing an oral risk assessment at > six months of age, the pediatrician or other pediatric health care provider believe a referral is necessary, the referral should be made to a pediatric dentist."

- We have made changes to
  1. 2-2 Comprehensive History
     We have changed our recommended developmental screening tools from the Pre-screening Developmental Questionnaire, the Denver Developmental Screening Test, and the Batelle Screening Test to:
     - Ages and Stages Questionnaire (ASQ)
     - Child Development Review (CDR)
     - Communication and Symbolic Behavior Scales Development Profile - Infants and Toddler (CSBSDP - Infant and Toddler Profile)
     - Infant Developmental Inventory (IDI)
     - Parent's Evaluation of Developmental Status (PEDS)

- We have added a website to
  1. 2-4 Age Appropriate Immunizations
     - Visit the CDC website, www.cdc.gov/nip/recs/child-schedule.htm#Printable, to access an updated childhood immunization schedule.

- We have added new language to
  1. 3-2 Dental Services
     - "Every child should begin to receive oral health risk assessment by six months of age by a pediatrician or other qualified pediatric health care provider" and that "by six months of age, if determined necessary by a pediatrician," referred to a dentist. (AAP recommendation)

- We have revised The Childhood Immunization Schedule (Appendix B).

- The revision states that "Influenza vaccine is recommended annually for children greater than six months of age with certain risk factors (including but not limited to children with asthma, cardiac disease, sickle cell disease, human immunodeficiency virus infection, and diabetes; and household members of persons in high-risk groups [see MMWR 2003;52(RR-8):1-36]) (www.cdc.gov/mmwr) and can be administered to all others wishing to obtain immunity. In addition, healthy children ages' six to 23 months are encouraged to receive influenza vaccine if feasible, because children in this age group are at substantially increased risk of influenza-related hospitalizations. For healthy persons age five to 49 years, the intra-nasally administered live-attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See MMWR 2003;52(RR-13):1-8. Children receiving TIV should be administered a dosage appropriate for their age (0.25 ml if age six to 35 months or 0.5 ml if age >three years). Children age < eight years who are receiving influenza vaccine for the first time should receive two doses (separated by at least four weeks for TIV and at least six weeks for LAIV).

- We have deleted
  1. 4-1 Billing for CHEC Exams
     - The CHEC/Well-Child screening form cannot be used for billing.

The revised SECTION 2 and immunization schedule are on the Internet. The link to the CHEC Manual is www.health.state.ut.us/medicaid. If you do not have Internet access, contact Medicaid Information for a copy of the revised CHEC Manual or use the Publication Request Form.

Should you have questions, you may contact Marilyn Haynes-Brokopp, CHEC Program Manager, at 801.538.6206 or mbrokopp@utah.gov. ☐

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04 - 65 Audiology

Code V5014, repair/modification of hearing aid will no longer require a prior authorization.
For repair services under $15.00, no itemization of services are required. For repairs exceeding $15.00, please itemize the services on the bill to Medicaid. For repairs which are sent to the manufacturer, because limited service was provided by the dealer, only the manufacturer' bill will be reimbursed to the hearing aid provider plus a fee for handling, assessing, and mailing. The manufacturer's Invoice must be attached to the Medicaid bill submitted by the hearing aid provider. See **chapter 4-2**, Repair limitations in the Medical Audiology Provider Manual. ☐

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04 - 66 Medical Transportation for Urgent Care

PickMeUp Medical Transport has the contract for most non-emergency medical transportation. Exceptions are bus travel, Flextrans and some isolated contracts for transportation. Under this contract transportation for urgent care has been provided. Beginning July 1, 2004 the following policy for urgent care transportation will be implemented:

Urgent care is non-emergency medical care which is considered by the prudent lay person as medically safe to wait 24 hours for medical attention. Urgent care does not require immediate medical attention. Waiting up to 24 hours will not be life threatening, cause permanent malfunction nor disability. If immediate medical attention is required, it is considered an emergency and should be transported by ambulance.

Transportation for urgent care must not require medical treatment during transit; such transportation must be provided by an ambulance. Usually recipients requesting urgent care will be transported to the nearest provider capable of providing the care, unless otherwise directed by a physician. Use of a hospital emergency room for non-emergency medical care is strongly discouraged.

- **Weekdays, business hours – 8:30 AM to 5:30 PM:** Transportation for urgent care is available during weekday business hours of 8:30 AM to 5:30 PM and is commonly provided to the recipient's physician office. If directed by the physician (or if the physician is unavailable), transportation will be to the nearest urgent care facility or walk-in clinic. If an urgent care facility or walk-in clinic is not available, the transport may be to the nearest hospital emergency room. Those clients who have managed care will be transported for urgent care as directed by the plan.
- **After business hours – 5:30 PM to 11:00 PM:** Transportation for urgent care is available between 5:30 PM and 11:00 PM weekdays to the nearest available urgent care facility or walk-in clinic. Transportation to the nearest hospital

emergency room for non-emergency medical care is strongly discouraged and will be provided only if there are no other open medical facilities capable of providing the needed urgent care. Those clients who have managed care will be transported for urgent care as directed by the plan.

- **Weekends or Holidays – 8:30 AM to 11:00PM:** Transportation for urgent care is available between 8:30 AM to 11:00 PM weekends or holidays to the nearest available urgent care facility or walk-in hours clinic. Transportation to the nearest hospital emergency room for non-emergency medical care is strongly discouraged and will be provided only if there are no other open medical facilities capable of providing the needed urgent care. Those clients who have managed care will be transported for urgent care as directed by the plan.
- **After 11 PM for all days:** Because it is medically safe to wait, transportation for urgent care after 11:00 PM will be provided the next morning after 8:30 AM and will be provided to the recipient's physician's office unless directed by the physician (or if the physician is unavailable) to an urgent care facility, walk-in clinic, or the nearest hospital emergency room. Transportation to a hospital emergency room for non-emergency medical care will only be made if there are no other open facilities capable of performing the needed medical care. Those clients who have managed care will be transported for urgent care as directed by the plan.
- **Releases from a Hospital Emergency Room:** Transportation following a release from a hospital emergency room for emergency treatment is covered. Transportation following a release from a hospital emergency room after non-emergency medical care is not covered unless the Medicaid contracted provider or ambulance has provided the transportation to the ER. Those clients who have managed care will be transported as directed by the plan.

Wheelchairs and transportation – Weight and Size Limitations

1. If the combined weight of the client and the power wheelchair exceeds the lift capacity as recommended by the lift manufacturer, and the client possess the strength and physical ability to "transfer," aided or unaided, they are not eligible for Medicaid transportation by the Medicaid transportation contractor unless the client is transported in a manual standard wheel chair. Such manual wheelchair may be provided by Medicaid or already be in the possession of the client.

2. If the combined weight of the client and the power wheelchair exceeds the lift capacity as recommended by the lift manufacturer, and the client does not possess the strength and physical ability to "transfer," aided or unaided, as certified by a physician or if they refuse to transfer to an appropriate manual chair, they are not eligible for transportation by Flextrans nor PMU. Medicaid may offer alternate safe transportation, such as an ambulance with the client in a supine position as no other safe transportation means are available. ☐

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04 - 67 Attention: Mental Health Centers

Corrections have been made to the Utah Medicaid Provider Manual for Mental Health Centers.
The section on Children in State Custody has been moved from Chapter 1-4 to Chapter 1-1. Chapter 1-8 has been revised to move part of item A to become B. Chapter 2-9 has also been corrected to accurately state who may provide pharmacologic management by prescriber, procedure code 90862.

Providers will find updated pages with corrections to these chapters. A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐

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04 - 68 Attention: Substance Abuse Treatment Providers

Revisions have been made to the Utah Medicaid Provider Manual for Substance Abuse Treatment Services. This manual has been updated to include information on providing services to children in State custody. This information is contained in Chapter 1-1. Along with this additional information, Chapter 1-7 has also been updated to include a new item B. that clarifies the treatment plan review schedule for children in State custody.

Providers will find updated pages with corrections to these chapters. A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐

04 - 69 Targeted Case Management Providers for the Chronically Mentally Ill, Targeted Case Management Providers for Substance Abuse and Targeted Case Management Providers for the Homeless:

Clarification of qualified targeted case managers has been made in Chapter 1-4, Chapter 4-5 and Chapter 1-4 respectively.

Substance abuse targeted case management providers will also find an updated Chapter 5-1 with clarification of covered case management activities. This clarification was made in the April 2004 Medicaid Information Bulletin; however, the chapter was inadvertently omitted from the mailing to some substance abuse providers.

Providers will find updated pages with corrections to these chapters. A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐

04 - 70 Physician Services

Codes covered
61975–stereotactic computer assisted volumetric procedure covered at surgical ranked rate

76820–transrectal ultrasound may be completed by a board-certified urologist who has completed training in ultrasound, as well as the radiologist. Since our system will not currently identify physician specialty, the claim must be submitted with information that the physician completing the procedure is a board certified urologist trained in ultrasound.

Code 99291 and 99292–critical care service
Note: The descriptor changed with 2004 CPT manual to allowance of the code for patients over 24 months of age. Pediatricians may continue to bill for hourly critical care time. Under Medicaid these two codes will continue to remain open for all ages as long as documentation supports the critical care time billed. Pediatricians may also continue to bill the initial and subsequent hospital care codes 99221-99233. The pediatric and neonatal critical care codes 99293-99299 will continue to be covered as outlined in the manual for providers meeting the required credentials.

Codes requiring submission of documentation for manual review
61793–stereotactic radiosurgery, one or more sessions (for lesion 3 cm or less)
93580–percutaneous transcatheter closure congenital interatrial defect (i.e. Fontan) with implant

43659–laparoscopic intestinal surgery
Note: Gastric bypass is not a covered service. Using this code to complete laparoscopic gasic bypass will result in a denial of service.

Update to Injectable Medication Policy in Physicians Manual
Botulinum toxin type A, item 5 under Limitations and Non-Coverage : Investigational and experimental us of Botulinum A is not covered. Therefore Boultinum Toxin type A is not covered for **migraine, sialorrhea** (excessive salivation or drooling), and **hyperhidrosis** (excessive sweating).

Updates to Criterion

#34 Benign skin lesion: add to item number (1) Lipoma not covered.

#33B Sacral Neurostimulator add to item number B All reasonable conservative treatments . . . (before current C item which will now be D)

C. The Agency for Health Care Policy and Research has developed guidelines for use of the sacral neurostimulator. Clinical Practice Guidelines for consideration of the implantation of the neurostimulator require patient evaluation preoperatively to exclude severe detrusor instability as well as to ensure adequate bladder stability. Patient has not responded to prior behavioral and pharmacologic interventions. Incontinence is not related to a neurologic condition in which the efficacy of the device is unproven. The patient with indications for trial implantations of the sacral neurostimulator device include:

1. Men six or more months post-prostatectomy who after behavioral and pharmacological therapies and/or other appropriate surgery have no improvement.
2. Patients with epispadias-exstrophy in whom bladder neck reconstruction has failed
3. Women with intractable urinary frequency who have failed behavioral, pharmacological and other surgical treatment.
4. Children with intractable urinary frequency due to myleomeningocele who are refractory to behavioral or pharmacological therapies and are unsuitable candidates for other types of surgical procedures for correction of urinary incontinence.

New Criterion

Positron emission tomography (PET) scans will be covered for site of service 01-hospital. Effective August 1, 2004, PET scans are not covered for site of service 70, independent radiology.

#40C PET imaging Criterion

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the body. Submission of claims for payment must include information indicating the PET scan was medically necessary, did not involve any investigational drugs or procedures, and wasn't unnecessarily duplicative of other diagnostic tests.

Coverage

A. PET is covered only in a clinical situation in which the PET results may assist in avoiding an invasive diagnostic procedure or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. PET scans following tissue diagnosis are preformed for the purpose of staging. Therefore, PET use for initial diagnosis of lymphoma, esophageal, melanoma, and colorectal cancers should be rare.

B. PET is covered for cancer staging and restaging when the cancer stage remains in doubt following standard diagnostic imaging (CT, MRI, or US) or when the PET is considered medically reasonable and necessary because the conventional imaging will not provide the information required for clinical management and the PET will replace one or more conventional imaging studies.

Limitations:

A. PET scans following a tissue diagnosis are covered only for staging after a diagnosis of lymphoma, melanoma, single pulmonary nodule, or colorectal cancer. In a patient with lymphoma a PET scan is covered for staging or followup after treatment. In a patient with melanoma a PET scan is covered to evaluate recurrence of melanoma prior to surgery and to assess extranodal spread of malignant melanoma at initial staging or during followup treatment. In a patient with colorectal cancer, a PET scan is covered for determination of location of recurrent tumors in rising CEA (carcinoembryonic antigen) blood level and to assess the resectability of hepatic or extrahepatic metastases of colorectal cancer and for staging and restaging

B. PET scan is not covered for the evaluation of CNS disease such as dementia, cerebrovascular disease, metabolic or nutritional disorders, infections, pulmonary disease, or for neoplasms of the liver, musculoskeletal system, ovary, pancreas, thyroid or parathyroid.

C. PET scan is not covered for screening in the absence of specific signs and symptoms of disease or as a work-up of patients with multiple sites of disease.

D. PET scan may be considered medically necessary in patients with an **unknown primary carcinoma who meet all of the following** criteria:

   a) there is a single site of disease outside of the cervical lymphnodes,

   b) the patient is considering a local or regional treatment of the single site of metastatic disease,

   c) the PET scan will be used following work up for an occult primary tumor to rule out or detect additional sites of disease that would eliminate the rational for local or regional treatment, and

E. Use of PET to monitor tumor response during the planned course of therapy is not covered except for breast cancer. In breast cancer, PET may be covered as an adjunct to standard imaging when a change in therapeutic treatment is anticipated. ☐

04 - 71 Medical Supplies

Wheelchairs for transportation

A standard manual second wheelchair may be allowed only for clients whose aggregated weight of client and power wheelchair exceeds the limitations of the power lifts on transportation vehicles. This is provided to allow clients to be transported in a manual wheelchair to Medicaid covered medical appointment without exceeding the lift capacity of the transportation vehicle. The second wheelchair will be appropriately sized to accommodate the size and weight of the recipient. This is the only circumstance wherein a second wheelchair is allowed.

Capped Rental Equipment

Beginning July 1, 2004, humidifier, code E0562; CPAP, code E0601; and BiPAP, codes E0470 and E0471 will be under a capped rental where twelve rentals will be paid and then rental payments are capped. A maintenance fee of one month rental may be charged every six months following the cap to reimburse for necessary service and maintenance of these specific items. These services all require a prior authorization.

Code Changes

Code A4419, Ostomy pouch, closed, with locking flange, has been open but not found in the manual. This is now in the Medical Supplies manual and has a limit of 60 per month.

S1015, IV tubing extension set, is discontinued. This not replaced but reimbursement is included in the global fees paid under S5520, and S5521, Home infusion therapy as well as A4221, supplies for maintenance of drug catheter.

L1907, AFO, supramalleolar, w straps, w or w/o interface, custom fabricated.

L5679, Addition to lower Extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket, insert, – not for use with locking mechanism, will replace K0557.

L5681, Addition to lower extremity, below knee/above knee, custom fabricated socket insert of congenital or atypical traumatic amputee, – with or without locking mechanism, will replace K0558.

L5683, Addition to lower extremity, below knee/above knee custom fabricated socket inset for other than congenital or atypical traumatic amputee, silicon, – with or without locking mechanism, will replace K0559.

L5673, Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or silicone gel, – with or without locking mechanism, will replace K0556.

K0114, Back support system for wheelchairs has been opened and requires a written prior authorization.

E0192, Low pressure/positioning equalization pad, wheelchair is open in the Medicaid Medical Supplier Manual but now requires a written prior authorization.

K0081, Wheel lock assembly, this code has been opened for repair of wheelchairs only and requires a written prior authorization.

A4368, Ostomy filter, any type is now open.

A4409, Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4x4 inches or smaller, each is now open.

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04 - 72 Attention: Licensed Psychologists:

Licensed psychologists will find attached a revised Section Two of the Utah Medicaid Provider Manual - Psychology Services. Many non-substantive changes have been made for clarification. A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐